TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 0 2 — 0 1 5

2. STATE: MA

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE

July 1, 2002

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
Section 1902(a)(13) and 1902(a)(30) of the Act and 42 CFR 447.250 through 447.272

7. FEDERAL BUDGET IMPACT:
a. FFY 02 $ $9.4M
b. FFY 03 $ $37.5M

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 4.19-D(4), pp. 1-13, and Appendices A and B

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

Attachment 4.19-D(4), pp. 1-13, and Appendices A, B, D, and E (Appendices D and E are being deleted)

10. SUBJECT OF AMENDMENT:

Nursing Facility Services

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
Not required under 42 CMR 430.12(b)(2)(:

12. SIGNATURE OF STATE AGENCY OFFICIAL:

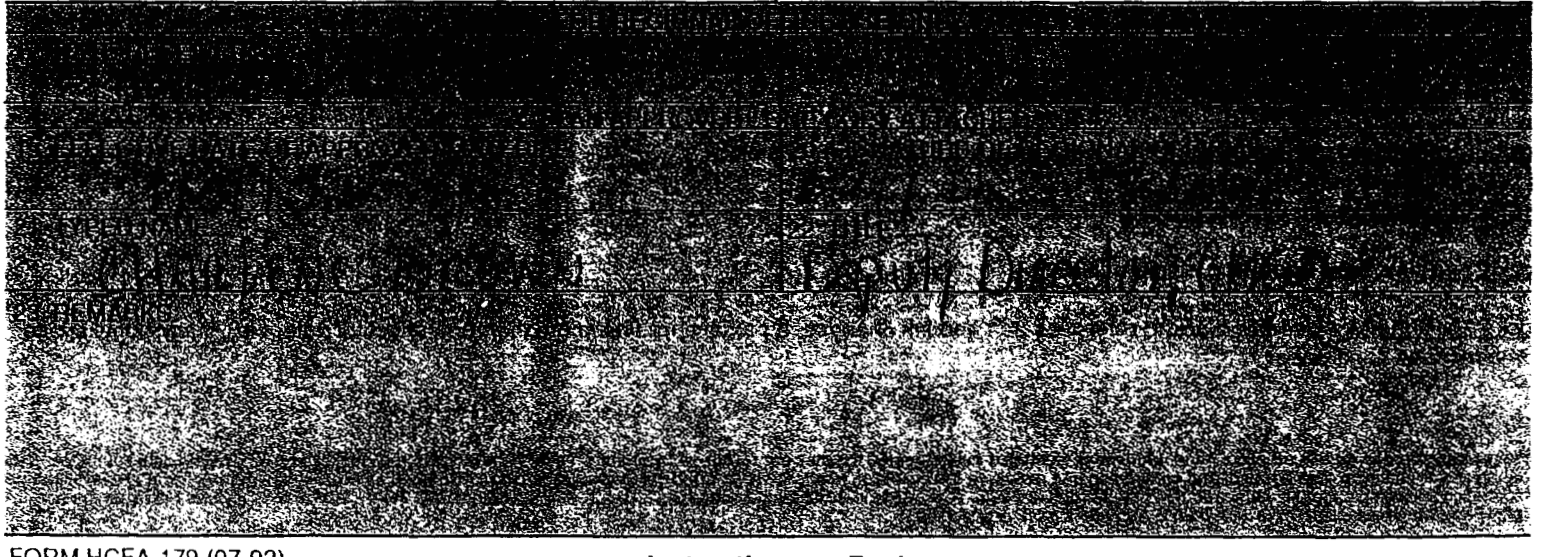
13. TYPED NAME:
Wendy E. Warring

14. TITLE:
Commissioner

15. DATE SUBMITTED:

16. RETURN TO:

Laura Watson
State PLan Coordinator
Divison of Medical Assistance
600 Washington Street
Boston, MA 02111



FORM HCFA-179 (07-92)

Instructions on Back

JANE SWIFT
Governor

ROBERT P. GITTENS
Secretary

WENDY E. WARRING
Commissioner

The Commonwealth of Massachusetts
Executive Office of Health and Human Services
Division of Medical Assistance
600 Washington Street
Boston, Massachusetts 02111

September 26, 2002

Robert Parris
Department of Health and Human Services
Centers for Medicare & Medicaid Services
John F. Kennedy Federal Building
Government Center
Boston, MA 02203

RE: TN 02-015, State Plan Amendment regarding Reimbursement for Nursing Facility Services

Dear Bob:

Attached for your review is TN 02-015, a State Plan Amendment to Attachment 4.19-D(4). To expedite your review, I have enclosed both a redlined copy and a non-redlined copy of the amendment and emailed them to you as well.

Should you have any questions about this amendment, please contact me at 617-210-5657 or Lisa McDowell at 617-210-5626.

Sincerely,

Laura Watson
State Plan Coordinator
Office of the General Counsel

cc: Medicaid National Reimbursement Team (NIRT)
CMS/CMSO
7500 Security Boulevard
Mail Stop S2-01-16
Baltimore, MD 21244-1850

The Commonwealth of Massachusetts
Executive Office of Health and Human Services
Division of Medical Assistance
600 Washington Street
Boston, Massachusetts 02111

JANE SWIFT
Governor

ROBERT P. GITTENS
Secretary

WENDY E. WARRING
Commissioner

September 23, 2002

Ronald Preston, Ph.D.
Health Care Financing Administration
John F. Kennedy Federal Building
Government Center
Boston, MA 02203

Re: TN-02-015, State Plan Amendment Regarding Methods Used to Determine Rates of Payment for Nursing Facility Services

Dear Dr. Preston:

Attached is TN-02-015, a State Plan Amendment to Attachment 4.19-D(4). This State Plan Amendment specifies comprehensively the methods and standards used by Massachusetts to set payment rates for nursing facilities, effective July 1, 2002. Payments for nursing facility services rendered to publicly assisted residents are governed by the Division of Health Care Finance and Policy (DHCFP) regulation, 114.2 CMR 6.00: Standard Payments to Nursing Facilities, attached as Appendix A of this submission. The methods and standards used and the aggregate payments to nursing facilities that result do not exceed the amount that can reasonably be estimated would have been paid in the aggregate for those services under Medicare payment principles (42 C.F.R. 447.272). In order to expedite your review all changes have been bolded and italicized.

The major changes from the previous submission, TN-02-001, are:

Page 1

Section I.A:

- Effective date of rates is July 1, 2002.

Page 7

Former Section III.F:

- The Total Payment Adjustment is eliminated (former Section III.F).

Appendices

- A new Appendix A (114.2 CMR: 6.00 (Division of Health Care Finance and Policy) is submitted.
- Former Appendix E is resubmitted as Appendix B with no other changes.
- Appendix C remains the same and is not resubmitted
- Appendices D and E are eliminated.

Should you have any questions regarding this amendment, please contact Lisa McDowell at 617-210-5626.

Sincerely,

Wendy E. Warring
Commissioner
Division of Medical Assistance

Enclosures: Form 179
State Plan Amendment 02-015 (not redlined)
State Plan Amendment 02-015 (redlined)
Appendices A and B to State Plan Amendment 02-015

State Plan under Title XIX of the Social Security Act
State. Massachusetts
Institutional Reimbursement: Nursing Facilities

Methods Used to Determine Rates of Payment for Nursing Facilities

I. General Description of Payment Methodology

A. **Overview.** Nursing facility payments for services rendered to publicly assisted residents are governed by the Division of Health Care Finance and Policy (DHCFP) regulation, 114.2 CMR 6.00: Standard Payments to Nursing Facilities. The following sections in this attachment describe the methods and standards used to establish payment rates for nursing facilities effective July 1, 2002.

B. **Chief Components.** The payment method, described below, completes the shift away from historical facility-specific cost-based reimbursement to standard payments for nursing facility services. Standard payments are derived from reported median base-year costs for Nursing and Other Operating Costs as well as a capital payment component. Nursing and Other Operating Standard Payment rates were calculated using Calendar Year (CY) 2000 costs updated by a cost adjustment factor (CAF) of 5.96%. The allowable basis for capital was updated using CY 2000 data.

II. Cost Reporting Requirements and Cost Finding

A. **Required Reports.** Each provider of long-term care facility services under the State Plan must complete an annual report (the "Annual Cost Report") containing cost information for the cost reporting year on the basis of generally accepted accounting principles and the accrual method of accounting. There are six reports required: a) Nursing Facility Cost Report; b) Realty Company Cost Report; c) Management Company Cost Report, d) Nursing Expense Reports, e) Financial Statements, and f) Collective Bargaining Agreements for Certified Nursing Assistants. All cost reporting must meet the requirements set forth in Appendix A (114.2 CMR 6.07 (2)). There are special cost reporting requirements for Hospital-Based Nursing Facilities and facilities that operate other programs such as Adult Day Health, Assisted Living or Outpatient Services. These requirements are outlined in Appendix A (114.2 CMR 6.07 (2)(f)).

B. **Filing Dates: Required Reports.** Except as provided below, providers must file Required Reports for the calendar year by 5:00 PM of April 1 of the following calendar year. If April 1 falls on a weekend or holiday, the Required Reports are due by 5.00 PM of the following business day.

1. **Change of Ownership**. Where there has been a change of ownership, the transferor shall file the report(s) within 60 days after the transfer of ownership. Where the transferor fails to submit the Report(s), DHCFP may request the Division of Medical Assistance (the Division) to withhold payment to the transferee until such reports are appropriately filed.

2. **New Facilities and Facilities with Major Additions**. For the first two calendar years of operation, New Facilities and Facilities with Major Additions shall file year-end Required Reports within sixty (60) days after the close of the calendar year.

3. **Hospital-Based Nursing Facilities**. A Hospital-Based Nursing Facility is a separately licensed unit housed on the premises of a facility that is licensed for both hospital and long-term care services, where the long-term care beds were converted from licensed hospital beds or otherwise acquired. Hospital-Based Nursing Facilities must file the Required Report(s) on a fiscal year basis that is consistent with the filing of such facilities' hospital cost reports. The Required Report(s) is due no later than ninety (90) days after the close of the facility's fiscal year.

4. **Termination of Provider Contract**. Whenever a provider contract between the provider and the Division is terminated, the provider shall file reports covering the current reporting period portion thereof covered by the contract and any other reports required by DHCFP, within 60 days of such termination. When the provider fails to file the Required Reports in a timely fashion, DHCFP shall notify the provider of this failure by written notice sent registered mail, return receipt requested.

5. **Appointment of Patient Protector Receiver**. If a receiver is appointed pursuant to court order under M.G.L. c. 111, s. 72N, the provider must file the Required Reports for the current reporting period or portion thereof within sixty (60) days of the receiver's appointment.

C. **Filing Extensions**. DHCFP may grant an extension, up to 45 calendar days, for submission of the Required Report(s). Extension must: (a) be submitted in writing to DHCFP by the provider and not by an agent or other representative; (b) show that exceptional circumstances exist precluding the provider from submitting the Required Report(s) in timely fashion; and (c) be submitted no later than 30 calendar days before the filing due date.

D. **Incomplete Submission**. DHCFP shall notify the provider within 120 days of receipt of the Required Reports if it finds that the submission is incomplete and shall specify what additional information is required to complete the submission. The provider shall file the necessary information with DHCFP within 25 days of the date of notification or by April 1 of the year the Required Report is filed, whichever is later. The Required Reports and all accompanying schedules are deemed to be filed with the DHCFP as of the date DHCFP receives complete submission.

If DHCFP fails to notify the provider within the 120-day period, the submission is considered complete and the Required Report(s) and all accompanying schedules are deemed to be filed with DHCFP as of the date of receipt.

E. **Audits**. DHCFP and the Division may conduct desk or field audits to ensure accuracy and consistency in reporting. Providers must submit additional data and documentation relating to the Required Reports, the operations of the provider and any related party as requested, even if DHCFP has accepted such Required Reports.

F. **Penalties for Failure to File Timely**. A provider's rate for current services will be reduced in accordance with 114.2 CMR 6.07 (7) (Appendix A) if the Required Reports are not filed in a timely manner. On receipt of such Required Reports, the provider's rate will be restored effective on the date of report filing.

G. **General Cost Principles**. In order to report a cost as related to MassHealth patient care, a cost must satisfy the following criteria:

1. the cost is ordinary, necessary, and directly related to the care of publicly aided patients;

2. the cost is for goods or services actually provided in the nursing facility;

3. the cost must be reasonable; and

4. the provider must actually pay the cost.

Costs that are not considered related to the care of MassHealth patients include, but are not limited to: costs that are discharged in bankruptcy; costs that are forgiven; costs that are converted to a promissory note; and accruals of self-insured costs that are based on actuarial estimates.

A provider may not report any of the costs that are listed in 114.2 CMR 6.07 (2) (e) (Appendix A) as related to MassHealth patient care.

State Plan under Title XIX of the Social Security Act
State. Massachusetts
Institutional Reimbursement: Nursing Facilities

III. Methods and Standards Used to Determine Payment Rates

A. **Prospective Per Diem Rates**. The prospective per diem payment rates for nursing facilities are derived from the Nursing, Other Operating, and Capital payment components. Each of these components is described in detail in the following sections.

B. **Nursing Cost**. The following Nursing Standard Payments (per diem) comprise the Nursing Cost component of the prospective per diem payment rates for nursing facilities.

Payment Group	Management Minute Range	Nursing Standard Payment
H	0 – 30	$10.95
JK	30.1 – 110	$28.48
LM	110.1 – 170	$51.40
NP	170.1 – 225	$72.28
RS	225.1 – 270	$90.76
T	270.1 & above	$108.80

The base year used to develop the Nursing Standard Payments is 2000. Nursing costs reported in listed above is CY 2000 in the following categories are included in the calculation: Director of Nurses, Registered Nurses, Licensed Practical Nurses, Nursing Aides, Nursing Assistants, Orderlies, Nursing Purchased Services, Director of Nurses and Nursing Workers' Compensation, Payroll Tax, and Fringe Benefits, including Pension Expense. The Nursing Standard Payments are derived from the product of the industry CY 2000 median nursing costs times the CY 2000 industry median management minutes for each of six payment groups listed 114.2 CMR 6.03 (1) (Appendix A, p. 5). The base year amounts for each group are updated to rate year 2002 by a cost adjustment factor of 5.96%. This cost adjustment factor is based on Massachusetts-specific CPI forecasts as well as national and regional indices supplied by DRI.

C. **Other Operating Cost**. The Other Operating Cost Standard Payment (per diem) comprises the other operating component of the prospective per diem payment rates for nursing facilities. The Other Operating Standard Payment, effective July 1, 2002, is $56.05.

The base year used to develop the Other Operating Standard Payment of $56.05 is CY 2000. Other operating costs reported in CY 2000 in the following categories are included in the calculation: variable, administrative and general, and motor vehicle costs. The Other Operating Standard Payment is set equal to the CY 2000 industry median of these cost amounts, except for administrative and general costs, which are subject to a ceiling of $11.48 before combining with other cost components. The calculation of the Other Operating Standard Payment is reduced by 2% to exclude nonallowable reported costs. The allowable base-year amount is updated by a CAF of 5.96%. This cost adjustment factor is based on Massachusetts-specific CPI forecasts as well as national and regional indices supplied by DRI.

D. **Capital.** The Capital component is computed in accordance with 114.2 CMR 6.05 (2) (Appendix A), using the allowable depreciation, financing contribution, and other fixed costs based on the allowable basis of fixed assets as of December 31, 2000.

1. **Determination of RY 2002 Capital Payments.** For beds licensed prior to July 1, 2002, the Capital payment will equal the lower of the facility's capital payment in its presently certified rates (in effect on January 1, 2002) or the revised payment calculated from the CY 2000 cost report data, as described in 114.2 CMR 6.05 (2) (c) (Appendix A).

2. **Capital Payments Exceptions.** For the following facilities that meet the criteria in 114.2 CMR 6.05 (1) (Appendix A), the Capital component per diem effective July 1, 2002 is $20.25:

   a) new facilities constructed pursuant to a Determination of Need approved after March 7, 1996;
   b) replacement facilities that open pursuant to a Determination of Need approved after March 7, 1996;
   c) new facilities in urban under bedded areas that are exempt from the Determination of Need process;
   d) new beds that are licensed pursuant to a Determination of Need approved after March 7, 1996;
   e) new beds in twelve-bed expansion projects not associated with an approved Determination of Need project;
   f) hospital-based nursing facilities; and
   g) private nursing facilities that sign their first provider agreement on or after July 1, 2002.

3. **Notification of Substantial Capital Expenditures.** Any nursing facility that opens, adds new beds, adds substantial renovations, or re-opens beds after July 1, 2002, is required to notify DHCFP in accordance with 114.2 CMR 6.05 (3) (a) (Appendix A). At that time, the Capital component may be recomputed in accordance with 114.2 CMR 6.05 (3) (b) (Appendix A).

E. **Add-on for Certified Nursing Assistants**. An add-on is computed in accordance with 114.2 CMR 6.06 (1) (Appendix A) for the purpose of funding increases in the salaries and associated payroll taxes of certified nursing assistants. DHCFP will conduct a retrospective review of the add-on to verify whether the add-on is expended as intended. If a nursing facility does not expend the add-on for certified nursing assistants as intended, DHCFP will notify the nursing facility to pay a 150% recovery amount, determined upon audit, to the certified nursing assistants.

F. **Retroactive Adjustments**. DHCFP will retroactively adjust rates according to 114.2 CMR 6.06 (2) (Appendix A) in the following situations: facilities that did not file a CY 2000 Cost Report, Amended Rates for Prior Years, Mechanical Errors, and Errors in the Cost Reports.

IV. Special Conditions

A. **Innovative and Special Programs**. The Division may contract for special and/or innovative programs to meet special needs of certain patients, which are not ordinarily met by existing services in nursing facilities. Currently, these programs include programs for patients with traumatic brain injury, mental illness and medical illness (MIMI's), technologic dependency, as well as a program for nursing facilities that have a substantial concentration of patients of the highest acuity level (i.e., Management Minute Category T).

B. **Rate for Innovative and Special Programs.** A provider who seeks to participate in an innovative and special program must contract with the Division to provide special care and services to distinct categories of patients designated by the Division. This is usually done through a Request for Responses by the Division for special or innovative programs to address special needs of certain patients that are not ordinarily met by existing services in nursing facilities. Payment under the innovative and special programs may be calculated based on the added reasonable and necessary costs and expenses that must be incurred (as determined by the Division) by a provider in connection with that program. The provider must verify that such items or services are furnished because of the special needs of the patients treated as contemplated in the contract with the MassHealth Program, and that such items or services are reasonable and appropriate in the efficient delivery of necessary health care. The rate for an innovative and special program may be established as an add-on to a rate established by DHCFP under 114.2 CMR 6.00 or as a stand-alone rate established by contract under M.G.L. c. 118E, §12 that is not subject to the provisions of 114.2 CMR 6.00. In either instance, the rate must be consistent with the payment methodology established herein for long-term care facilities. In the event that the special program is located within a special unit, the remaining costs of the unit are to be integrated into the cost report for the entire facility.

C. **Nursing Facilities Converted from Non-Acute Hospitals.** A facility that has recently converted from a facility providing non-acute hospital services to a facility providing nursing facility services may be reimbursed as a special program. In order to be considered as a special program, such a facility must agree to provide, or arrange and pay for, all MassHealth covered services, except hospital services, to all MassHealth recipients who are residents of the facility. The reimbursement to such facilities is a per diem rate that is the facility's regular case-mix rates with an add-on that is based on the reasonable costs of providing the goods and services beyond those required to be provided by nursing facilities.

D. **Facilities with High-Acuity High-Nursing Need Residents.** A provider whose resident population primarily and consistently consists of high-acuity high-nursing need residents such that the aggregate need of the entire population requires a staffing level significantly greater than a typical nursing facility may be reimbursed as a special program, in which case the increment added to the facility's rate may apply to all residents of the facility and will be calculated based on allowable costs associated with the higher care needs of the patients. In order to be eligible for reimbursement under this paragraph, a nursing facility must meet each of the following criteria:

1. at least ninety percent (90%) of its residents must have Management Minute ("MM") scores that fall in either MM category 9 or 10 and at least seventy-five percent (75%) of its residents must have MM scores that fall in MM category 10; or (ii) the facility must be a former acute hospital that has undergone conversion to a nursing facility under the auspices of the Massachusetts Acute Hospital Conversion Board;

2. the mean MM score for all residents of the facility in MM category 10 must be at least fifteen percent (15%) higher than the minimum score needed to qualify for MM category 10; and

3. the facility must be a geriatric nursing facility.

E. **Pediatric Nursing Facilities.** Payments will be determined using CY 2000 reported costs for Nursing and Other Operating Costs, excluding Administration and General Costs. Administration and General Costs will be subject to a cap of $12.73.

F. **Pilot Program for Ancillary Costs.** Nursing facilities that applied to the Division to participate in an alternative Ancillary Pilot Program for payment of ancillary services may receive incentive payments. Participation is voluntary, subject to approval by the Division. Appendix E contains the payment methodology for incentive payments that may be made to the providers who participated in the voluntary Ancillary Pilot Project commencing in December 1, 1998.

G. **Beds Out of Service.** Facilities with licensed beds that were out of service prior to 2001 that re-open in 2001 will receive the lower of the Standard Payment rates or the most recent prior payment rates adjusted by the applicable CAF for Nursing and Other Operating Costs.

H. **Legislative Mandate for Rate Relief.** A nursing home with the following conditions shall have all of its variable costs and nursing cots recognized by DHCFP and its MassHealth rate adjusted accordingly:

(i) with rate of public utilization consisting of Medicare, MassHealth, and Commission for the Blind patients, of ninety percent or more;
(ii) located in the service area of a federally designated sole community hospital; and
(iii) with more than 10% of its variable costs and nursing costs disallowed by DHCFP pursuant to 114.2 CMR 5.00 or any successor regulations.

DHCFP shall adjust the prospective rates for any nursing home that meets the aforementioned criteria for the rates that were effective January 1, 1994, and for each succeeding rate year that such nursing home complies with aforementioned criteria. The amount of variable costs and nursing costs recognized as allowable by DHCFP for any rate for a nursing home is limited to an amount that will not increase costs to MassHealth in an amount greater than $3,000. Notwithstanding anything to the contrary contained in this paragraph, in no case shall the provisions of this paragraph apply to any services rendered prior to February 1, 1998.

Any nursing facility that meets all of either the standards set forth in either Alternative A or Alternative B below shall have its total acquisition costs allowed as the allowable basis of fixed assets, notwithstanding any limits on the same that appear elsewhere in this State Plan, when the Division calculates the facility's payment rates. This provision shall only apply to services rendered on or after February 1, 1998.

a. Alternative A

- The owner purchased the nursing home on or after January 1, 1987.
- The owner has received a determination letter from the Internal Revenue Service that it is an organization described in section 501 (c) (3) of the Internal Revenue Code of 1986.
- The owner (i) owns a nonprofit hospital (the "Hospital") located within the Commonwealth of Massachusetts that is licensed by the Department of Public Health or (ii) is a nonprofit organization affiliated with a nonprofit hospital that is organized and operated for the benefit of, to perform one or more functions of, or to carry out one or more of the purposes of the nonprofit hospital it is affiliated with, including operation of freestanding nursing homes licensed by the Department of Public Health.
- The owner's patient population is, on average, not less than 85% MassHealth recipients.
- The Hospital has, on average, not less than 80% occupancy of medical or surgical beds.
- When the owner purchased the nursing facility (i) the change of ownership did not occur between a person or organization that is associated or affiliated with or has control of or is controlled by the owner or is related to the owner or any director, trustee, partner, shareholder, or administrator of the owner by common ownership or control or in manner specified in section 267 (b) and (c) of the Internal Revenue Code of 1986; (ii) the change of ownership was made for reasonable consideration; (iii) the change in ownership was a bona fide transfer of all powers and indicia of ownership; and (iv) the change of ownership manifested an intent to sell the assets of the facility rather than implement a method of financing or refinancing.

b. Alternative B

- The owner acquired the nursing facility from an acute care hospital to operate the facility pursuant to relief granted to the acute care hospital by the Acute Care Hospital Conversion Board pursuant to M.G.L. c.6A, s.101.
- The Acute Care Hospital Conversion Board approved the owner's acquisition costs of the facility.
- On average, no less than 85% of the nursing facility's patient population are MassHealth recipients.

I. **Martha's Vineyard Hospital Foundation.** Notwithstanding anything to the contrary contained in this State Plan, any nursing home that is owned by the Martha's Vineyard Hospital Foundation during the time that said Foundation also administers a federally designated sole community provider hospital shall have allowed all of its extra variable and fixed costs that reasonably result from such nursing home being located in a geographically isolated area.

J. **Receivership under M.G.L. C.111 s.72N *et seq.* (see Appendix C).** Provider rates of a nursing facility in receivership may be adjusted by DHCFP to reflect the reasonable and necessary costs associated with the court-approved closure of the facility.

K. **Review and Approval of Rates and Rate Methodology by the Division.** Pursuant to M.G.L c 118E, s.13, the Division shall review and approve or disapprove any change in rates or in rate methodology proposed by DHCFP. The Division shall review such proposed rate changes for consistency with state policy and federal requirements, and with the available funding authorized in the final budget for each fiscal year prior to certification of such rates by DHCFP; provided that, the Division shall not disapprove a rate increase solely based on the availability of funding if the Centers for Medicaid and Medicare provide written documentation that federal reimbursement would be denied as a result of said disapproval and said documentation is submitted to the Massachusetts House and Senate Committees on Ways and Means. The Division shall, whenever it disapproves a rate increase, submit the reasons for disapproval to DHCFP together with such recommendations for changes. Such disapproval and recommendations for changes, if any, are submitted to DHCFP after the Division is notified that DHCFP intends to propose a rate increase for any class of provider under Title XIX but in no event later than the date of the public hearing held by DHCFP regarding such rate change; provided that no rates shall take effect without the approval of the Division. DHCFP and the Division shall provide documentation on the reasons for increases in any class of approved rates that exceed the medical component of the consumer price index to the Massachusetts House and Senate Committees on Ways and Means.

L. **Statistical Information from DHCFP.** DHCFP shall supply the Division with all statistical information necessary to carry out the Division's review responsibilities under this Section.

M. **Supplemental Funding.** If projected payments from rates necessary to conform to applicable requirements of Title XIX are estimated by the Division to exceed the amount of funding appropriated for such purpose in the budget for the fiscal year, the Division and DHCFP shall jointly prepare and submit to the Governor a proposal for the minimum amount of supplemental funding necessary to satisfy the requirements of the State Plan developed by the Division under Title XIX of the federal Social Security Act.